DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Physical Therapists
Managed Care Plans

Memorandum No: 04-88 MAA
Issued: December 10, 2004

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Subject: Physical Therapy Program: Fee Schedule Changes

Effective for dates of service on and after January 1, 2005, the Medical Assistance Administration will:

- Begin using 2005 Current Procedural Terminology (CPT)® and Healthcare Common Procedure Coding System (HCPCS) Level II code additions as discussed in this memorandum; and
- Add maximum allowable fees for the new codes.

Added and Deleted Procedure Codes

MAA is deleting CPT code 97601 for selective wound debridement and replacing this code with CPT codes 97597 and 97598. Do not bill MAA using CPT code 97601 for dates of service after December 31, 2004.

Procedure Code	Brief Description	January 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97597	Active wound care/20 cm or <	$29.24	$29.24
97598	Active wound care > 20 cm	37.18	37.18
97605	Neg press wound tx, < 50 cm	Bundled	Bundled
97606	Neg press wound tx, > 50 cm	Bundled	Bundled

Billing Instructions Replacement Pages

Attached are replacement pages 11/12 and 15/16 for MAA's current *Physical Therapy Program Billing Instructions*. **Note: Pages 12 and 16 have no added or deleted codes; we are including them because we have reformatted them or because they are attached to the back or front of a changed page.**

How can I obtain MAA's Provider Issuances?

To obtain MAA's numbered memoranda and billing instructions, visit MAA's website at http://maa.dshs.wa.gov (select the *Billing Instructions/Numbered Memoranda* link).

To request a free hard copy from the Department of Printing:

- **Go to:** http://www.prt.wa.gov/ (Orders filled daily)
  Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Medical Assistance Administration → desired issuance; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-8831/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

The following are not included in the physical therapy program 48-unit limitation [Refer to WAC 388-545-500 (8)]:

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Checkout for orthotic/prosthetic use (CPT code 97703). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Muscle testing (CPT codes 95831-95834). One muscle testing procedure is allowed per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Evaluation of physical therapy (CPT code 97001). Allowed once per calendar year, per client. Use CPT code 97001 to report the initial evaluation before the plan of care is established by the physical therapist or the physician. This is to evaluate the client's condition and establishing the plan of care.

- Re-evaluation of physical therapy (CPT code 97002). Allowed once per calendar year, per client. CPT code 97002 is for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This evaluation is for reevaluating the client's condition and revising the plan of care under which the client is being treated.

- Wheelchair needs assessments (CPT code 97703). One allowed per calendar year. Four physical therapy program units are allowed per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). Two allowed per calendar year. Two physical therapy program units are allowed per assessment. Indicate on the claim that this is a DME needs assessment.

- MAA reimburses Physical Therapists for active wound care management involving selective and non-selective debridement techniques to promote healing using CPT codes 97597, 97598, and 97602. The following conditions apply:

  - ✓ MAA allows one unit of CPT code 97597 **or** 97598 **or** 97602 per client, per day. Providers may not bill CPT codes 97597, 97598, or 97602 in conjunction with one another.

  - ✓ Providers must not bill procedure codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy beyond that which is allowed by diagnosis, the provider must request MAA approval to exceed the limits.

Limitation extensions (LEs) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all eligibility groups receive all services. For example: therapies are not covered under the medically indigent (MI) program.

Limitation Extensions

Limitation Extensions are cases where a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instruction and Washington Administrative Code (WAC). Providers must use the EPA process to create their own EPA numbers. These EPA numbers are subject to post payment review.

In cases where the EPA cannot be met and the provider feels that additional services are medically necessary, the provider must request MAA approval for limitation extension. The request must state the following in writing:

1. The name and Patient Identification Code (PIC) of the client;
2. The therapist's name, provider number, and fax number;
3. The prescription for therapy from the provider. A letter describing the client's condition and the need for therapy is helpful;
4. The number of units and procedure codes used during calendar year;
5. The number of additional units and procedure codes needed;
6. The most recent therapy progress notes;
7. Copy of the physical therapy evaluation;
8. If therapy is related to an injury or illness, the date(s) of injury or onset of illness;
9. If surgery has been done, date(s) of surgery;
10. The primary diagnosis or ICD-9-CM diagnosis code; and
11. The reason why the client needs more therapy and why he or she is not independent in a home exercise program.

Send your request to:

MAA – Division of Medical Management
Limitation Extensions
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471

Procedure Code	Brief Description	January 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97504	Orthotic training	$18.59	$18.59
97520	Prosthetic training	17.00	17.00
97530	Therapeutic activities	17.68	17.68
97535	Self care mngment training	18.14	18.14
97537	Community/work reintegration	16.55	16.55
97542	Wheelchair mngment training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97597	Active wound care/20 cm or <	29.24	29.24
97598	Active wound care > 20 cm	37.18	37.18
~~97601~~	~~Wound care selective~~ Deleted 01/01/05	~~23.58~~	~~23.58~~
97602	Wound care non-selective	19.50	19.50
97605	Neg press wound tx, < 50 cm	Bundled	Bundled
97606	Neg press wound tx, > 50 cm	Bundled	Bundled
Tests and Measurements			
97001	Pt evaluation	45.11	38.77
97002	Pt re-evaluation	23.80	19.50
97703	Prosthetic checkout	15.42	15.42
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97750	Physical performance test	17.46	17.46
97755	Assistive technology assessment	21.08	21.08
Other Procedures			
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an initial claim within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

---

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider MUST refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service.